

07311

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 4 yrs., 1 mo. 6 days		3. VOl - 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 12 S. East Ave., Balto. 24, Md.	
3. NAME OF DECEASED (Type or print) First Ida Middle L. Last ALBERT		4. DATE OF DEATH Month July Day 14 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Edward J. McGloin		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334x (b) Arteriosclerotic heart disease DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH Days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jun 8, 1953 , to July 14, 1957 , that I last saw the deceased alive on July 14, 1957 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/15/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly + Zeiler Inc. ADDRESS 403 S. Wolfe		24a. REC'D BY REGISTRAR DATE 7/16/57	24b. REGISTRAR'S SIGNATURE C. Harry Skers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH REGISTRATION

BUREAU V. 3

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 7, 13, & 14 Film C218 7/21/57 cap
07312
CERTIFICATE OF DEATH

47296

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u> c. LENGTH OF STAY IN 1b <u>75 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>314 Diamond Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle _____ Last <u>Baskerville</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>19 57</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1900 ??</u>		9. AGE (In years last birthday) <u>57 3/4</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dishwasher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>From admission application</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerosis, general</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u> <u>Moderately advanced pulmonary tuberculosis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 29</u> , 19 <u>57</u> , to <u>July 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>57</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>T. F. Vestal</u> M.D. <u>Henryton, Maryland</u> <u>7-13-57</u> PHYSICIAN'S NAME (Type) <u>T. F. Vestal, M.D., Supt.</u> <u>Henryton State Hospital, Henryton, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell Inc. Med School</u>				24. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>Albert R. Swankhouse</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND - DEPARTMENT OF MENTAL HYGIENE

1957 18 JUL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07313

CERTIFICATE OF DEATH

07298

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>			
c. LENGTH OF STAY IN 1b <i>10 years</i>				d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Agnes Virginia BURDETTE</i>				4. DATE OF DEATH Month <i>7</i> Day <i>4</i> Year <i>1957</i>			
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 18, 1888</i>	
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Franklin Hoffmaster</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>217-12-1432A</i>			
17. INFORMANT Address <i>Mrs. Delton Glass - Sykesville, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident (recurrent)</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cardiac failure</i> DUE TO (c) <i>generalized arterio-sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 wks</i> <i>3 wks</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>September, 1955</i> , to <i>July</i> , 1957, that I last saw the deceased alive on <i>July 1</i> , 1957, and that death occurred at <i>9:55</i> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Bertrand R. Galt</i>				ADDRESS (Street, city or town, state) <i>37 Central Ave. Sykesville</i>			
DATE SIGNED <i>7-4-57</i>							
PHYSICIAN'S NAME (Type) <i>Bertrand R. GALT M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-6-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Pine Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Mt Airy, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Arthur H. Haight - Sykesville, Md.</i>							
24a. REC'D BY REGISTRAR DATE <i>7-5-57</i>				24b. REGISTRAR'S SIGNATURE <i>E. Henry Jones</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

07314

CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07315

CERTIFICATE OF DEATH

Reg. Dist. No. 81

07340

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Union Bridge</u>				c. LENGTH OF STAY IN 1b <u>12 years</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edman</u> Last <u>Cramer</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 16, 1874</u>			
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mining</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Elias Cramer</u>					
14. MOTHER'S MAIDEN NAME <u>Catherine Bennett</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>172-18-0289</u>				17. INFORMANT <u>Mr. Frank W. Cramer, R#1, Union Bridge, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>								INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u> <u>15 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>June 30</u> , 19 <u>57</u> , to <u>July 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>57</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>R. S. McVaugh</u>				ADDRESS (Street, city or town, state) <u>Taneytown, Md.</u>					
PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>				DATE SIGNED <u>7/2/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>United Bretheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Belsano, Penna.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mervyn C. Fuss</u>				24a. REC'D BY REGISTRAR <u>DATE 7/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>Leslie Rupp</u>			

BUREAU V. 2

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07316

CERTIFICATE OF DEATH

07301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 80 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tysakin <i>22 x 22</i> ✓			
f. STREET ADDRESS Rout 1 Box 141				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Norman Dashiell				4. DATE OF DEATH July 4 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-6-1902	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Tysakin, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Dashiell				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-07-6134		17. INFORMANT Cecil Dashiell-wife Address Same as patient	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis DUE TO with large capacity over the right upper Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from April 15 1957 , to July 4 1957 , that I last saw the deceased alive on July 4 1957 , and that death occurred at 7:00P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 7-4-57							
ACTUAL SIGNATURE <i>T. F. Vestal</i> M.D. Henryton, Maryland							
PHYSICIAN'S NAME (Type) Dr. Tom F. Vestal, Supt.				Henryton State Hospital Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-57		22c. NAME OF CEMETERY OR CREMATORY Burial		22d. LOCATION (City, town, or county) (State) Tysakin Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Travis A. Hensley</i> ADDRESS W. B. Hill St.				24a. REC'D BY REGISTRAR <i>W. B. Hill</i> DATE _____		24b. REGISTRAR'S SIGNATURE <i>Albert R. Swankham</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PUNEAU V. A.

1957 8

RECEIVED

07317

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marblehead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Detour</u>	
c. LENGTH OF STAY IN 1b <u>3 mo</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Delaplane</u> Last <u>Delaplane</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Gash</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Birely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. J. Etchison</u>		Address <u>116 Cent St Indial Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>440A</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Cardio-renal Vascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>57</u> , to <u>July 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>57</u> , and that death occurred at <u>11:15</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u>7-1-57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>		ADDRESS (Street, city or town, state) <u>Hampstead Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hugh's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>New Midway, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 7/3/57</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. W. R. S. Dennis</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07318

CERTIFICATE OF DEATH

Reg. Dist. No.

07304
3374

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Home		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jessie Duvall Dew		4. DATE OF DEATH Month Day Year July 13, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1867
9. AGE (In years last birthday) yrs. 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles S. Duvall	
14. MOTHER'S MAIDEN NAME Mollie Baldwin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Carlton Chilcoat, Glyndon, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease with DUE TO Arteriosclerosis and chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 10 20
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 23 November, 1954 , to 13 July, 1957 , that I last saw the deceased alive on 13 July, 1957 , and that death occurred at 16:50A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Liberty Road at Eldersburg DATE SIGNED 7.13.57			
ACTUAL SIGNATURE Wm. H. Lawson, Jr., M.D.		M.D. Liberty Road at Eldersburg 7.13.57	
PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.		Sykesville P.O., Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 16/57	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 7-13-57	
24b. REGISTRAR'S SIGNATURE C. Harry Steers			

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1057-1058

07319

CERTIFICATE OF DEATH

07305 74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN TB 2 mos. 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Victoria Middle Leeanna Last Pleasant DIXON				4. DATE OF DEATH Month July Day 24 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84		IF UNDER 24 HRS Days 84 Hours 84 Min 84			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia-	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Christopher Pleasant				14. MOTHER'S MAIDEN NAME Victoria Southerde			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) -				INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17, 1957 to July 24, 1957 , that I last saw the deceased alive on July 24, 1957 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/24/57			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc				ADDRESS 1217 St. Paul St.		24a. REC'D BY REGISTRAR DATE 7/26/57	
				24b. REGISTRAR'S SIGNATURE C. Harry Hess			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07396

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07320

Item 9 Filmur 18 7-29-57 et

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Etta Estella Miller DOERR		4. DATE OF DEATH Month Day Year July 16, 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1874
9. AGE (in years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. C. Miller		14. MOTHER'S MAIDEN NAME Nancy Engle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 444	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation 304X DUE TO Conditions, if any, which gave rise to immediate cause (b) 304X (c), stating the underlying cause last. 304X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. C.B.S. due to senile changes with psychosis. Osteoporosis of bone due to prolonged malnutrition with fractures of both legs and two ribs. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Probably spontaneous as patient was being turned in bed.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1:30 7/11/ 19 57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/20/57	
22c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE		22d. LOCATION (City, town, or county) (State) GRANTSVILLE GARRETT Co, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Newman Funeral Home Grantsville		24a. REC'D BY REGISTRAR DATE 7-17-57	
24b. REGISTRAR'S SIGNATURE C. Harry Wilson			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

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CERTIFICATE OF DEATH

Reg. Dist. No.

80

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>1 MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) <u>DAWSON HAMMOND ECKER</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/1864</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-TENANT RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FREDERICK ECKER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH FRITZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS CURTIS BARNES</u>				Address <u>NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease</u> DUE TO (c) <u>5 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Dec. 1, 1952</u> , to <u>7/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>57</u> , and that death occurred at <u>5:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u>				ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u>			
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>				DATE SIGNED <u>7/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. A. [Signature]</u>				ADDRESS <u>New Windsor, Md.</u>		24a. REG'D BY REGISTRAR DATE <u>JUL 25 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ernie Benedict</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 25 1957

BUREAU W. F.

07322

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b Since 11-29-55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 109 E. 4th Street			
3. NAME OF DECEASED (Type or print) First CARL Middle PORTER Last EDWARDS				4. DATE OF DEATH Month July Day 17 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-12-97	
9. AGE (In years last birthday) 60 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY W. Virginia		11. BIRTHPLACE (State or foreign country) W. Virginia	
13. FATHER'S NAME Bates Edwards				14. MOTHER'S MAIDEN NAME Mary Brillhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I				16. SOCIAL SECURITY NO 326- 16 0798		17. INFORMANT Springfield State Hospital - Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with alcohol intoxication, with psychotic reaction.						INTERVAL BETWEEN ONSET AND DEATH 1-2 minutes more than 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11-29 , 19 55 , to 7-17 , 19 57 , that I last saw the deceased alive on 7-16 , 19 57 , and that death occurred at 7:40AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7-17-57 ACTUAL SIGNATURE Martin Gross M. D. PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-20-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick MD.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline				ADDRESS Frederick Maryland		24a. REC'D BY REGISTRAR DATE 19 July 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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JUL 21 1964
BUREAU V. S.

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24b REGISTRAR'S SIGNATURE

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JUL 11 1957

BUREAU V. 2

07324

CERTIFICATE OF DEATH

Reg. Dist. No.

0731074

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN TB 19 y 4 m 28 d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last Sadie Virginia Evans				4. DATE OF DEATH Month Day Year 7 27 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-21-18	
9. AGE (In years last birthday) 38 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Felix Evans				14. MOTHER'S MAIDEN NAME Rosie B. O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) none (c) none DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with Mental Deficiency							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20-1954 to 7-26-1957 , that I last saw the deceased alive on 7-26-1957 , and that death occurred at 8:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 7-27-57							
PHYSICIAN'S NAME (Type) Edmund Lusthaus				SYLVANIA, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/57		22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery		22d. LOCATION (City, town, or county) (State) Mineral County, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Harper				ADDRESS Cumberland, Md.			
4a. REC'D BY REGISTRAR C. Barry Harp				DATE 8-1-1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 1 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07325
CERTIFICATE OF DEATH

07311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weitzel Nursing Home				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William E Falconer				4. DATE OF DEATH Month July Day 22 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1869	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Market, Md.		
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Eldred Falconer				14. MOTHER'S MAIDEN NAME Frances Penn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-9160		17. INFORMANT Lucian K. Falconer, New Market, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Heart disease, bronchitis, anemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 502.1							INTERVAL BETWEEN ONSET AND DEATH March 57 to July 57
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March , 1957, to July , 1957, that I last saw the deceased alive on 22 July 57 , and that death occurred at 2:0 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall		M.D.		ADDRESS (Street, city or town, state) Sykesville, Md.		DATE SIGNED 22 July 57	
PHYSICIAN'S NAME (Type) Howard E. Hall		Sykesville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25, 1957	22c. NAME OF CEMETERY OR CREMATORY New Market		22d. LOCATION (City, town, or county) (State) New Market, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE 7-26-57		24b. REGISTRAR'S SIGNATURE Robert R. Hurvitt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUL 30 1957

BUREAU V. S.

may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07312

07326

CERTIFICATE OF DEATH

Reg. Dist. No.

78

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Keymar</u>				c. LENGTH OF STAY IN 1b <u>15 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Calvin Foreman</u>				4. DATE OF DEATH Month Day Year <u>July 19, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Foreman</u>				14. MOTHER'S MAIDEN NAME <u>Annie Bankert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Howard Foreman, Keymar, Maryland R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mell.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2-6-1956</u> , to <u>7-19-1957</u> , that I last saw the deceased alive on <u>7-19-1957</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Union Bridge Md 7-19-57</u> ACTUAL SIGNATURE <u>J. N. Legg M.D.</u> PHYSICIAN'S NAME (Type) <u>J. H. Legg M.D.</u> <u>Union Bridge Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				24a. REC'D BY REGISTRAR <u>Jul 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>May Farrow</u>	

RECEIVED

JUL 22 1957

BUREAU V. S.

(7327

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>22yrs, 4mo, 15dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>147 East Baltimore Street</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Albert</u> Last <u>FORSYTHE</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 16, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Transfer work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own horse & wagon</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Wilbur Forsythe</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Jane Shipp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO <u>Unk.</u>		17. INFORMANT Address <u>Springfield Hospital records</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary artery thrombosis</u> days DUE TO (c) <u>Arteriosclerotic heart disease</u> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General paresis. Bronchopneumonia.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 7, 1955</u> , to <u>July 1, 1957</u> , that I last saw the deceased alive on <u>July 1, 1957</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>7/1/57</u>							
ACTUAL SIGNATURE <u>Agustin del Campo</u> M.D.				PHYSICIAN'S NAME (Type) <u>Agustin del Campo</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>	
22d. LOCATION (City, town, or county) <u>Hagerstown</u>				22e. (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Krauss</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7-2-57</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Egan</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be furnished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

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07328

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8yrs, 5mos, 11dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mildred Middle May Last GREEN		4. DATE OF DEATH Month July Day 29 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 25, 1919
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Green		14. MOTHER'S MAIDEN NAME Mary A. Scharfe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 71-244	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital endocrinopathic imbecile with epilepsy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 to July 29, 1957 , that I last saw the deceased alive on July 29, 1957 , and that death occurred at 4:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/30/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-1-57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) BALTO 7-46
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook ADDRESS 1217 S. Paul St		24a. REC'D BY REGISTRAR DATE 7-30-57 24b. REGISTRAR'S SIGNATURE C. A. Berry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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RECEIVED

JUL 31 1957

BUREAU V. B.

07329

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville R. 1				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION London Bridge Rd. & Cherrytree L.				e. STREET ADDRESS London Bridge Rd. & Cherrytree			
3. NAME OF DECEASED (Type or print) First Anna Middle Melissa Last Griffiee				4. DATE OF DEATH Month July Day 31 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1864	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months 3 Days 15 Hours 57	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George Washington Phillips				14. MOTHER'S MAIDEN NAME Mary Elizabeth Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. — — — —		17. INFORMANT Arthur H. Griffiee R. 1 Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. CAUSE WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ascending colon 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May , 19 48 , to July 31 , 19 57 , that I last saw the deceased alive on July 31 , 19 57 , and that death occurred at 2:50 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Julius Chepko				ADDRESS (Street, city or town, state) 85 1/2 W. Green St Westminster, Md.			
PHYSICIAN'S NAME (Type) Julius Chepko				DATE SIGNED 7/31/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-57		22c. NAME OF CEMETERY OR CREMATORY Family Plot On Farm		22d. LOCATION (City, town, or county) (State) Sykesville R. 1 Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR 8-3-57	
				24b. REGISTRAR'S SIGNATURE Harriet Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 20 Film 218 7-18-57 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

07316

67330

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>F.</u> Last <u>Hahn</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 19, 1877</u>	9. AGE (In years last birthday) <u>79 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Hahn</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Sowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. William Hahn</u> Address <u>Westminster, Md. R.F.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage -</u> <u>902.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull from fall</u> DUE TO (c) <u>from load of hay -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost balance and fell from top of load of hay to barn floor, landed on head</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> a. m. <u>7/6/57</u> 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>in barn</u>	
20f. (City or town) <u>nr. Uniontown</u>				20g. (County) <u>Carroll</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>7/6</u> , 19 <u>57</u> , to <u>7/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Hahn</u>				ADDRESS (Street, city or town, state) <u>Westminster, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>SILVSTER BARE</u>				DATE SIGNED <u>7/6/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keysville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				24a. REC'D BY REGISTRAR <u>JUL 9 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hahn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7331
CERTIFICATE OF DEATH

07317
8/

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENEDUM ST</u>				d. STREET ADDRESS <u>BENEDUM ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERNARD MILTON HESSON</u>				4. DATE OF DEATH Month Day Year <u>JULY 20 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHANIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT PLANT</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MILTON HESSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH STEM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-03-1065</u>			
				17. INFORMANT Address <u>MARY T. HESSON UNION BRIDGE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>General Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr 1955</u> to <u>7-20-1957</u> , that I last saw the deceased alive on <u>7-20-1957</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> DATE SIGNED <u>7-20-57</u>			
PHYSICIAN'S NAME (Type) <u>T. H. LE G G M D</u>				<u>Union Bridge Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Harker</u> ADDRESS <u>Union Bridge Md</u>				24a. REC'D BY REGISTRAR <u>Julius A. Keph</u>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. 2

U. L. 20 1957

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
07332

08397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) SYKESVILLE c. LENGTH OF STAY IN 1b 30yrs-1mo.-21days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fallston d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) MARY OLIVIA HITCHCOCK		4. DATE OF DEATH Month 7- Day 1- Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-06
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL W. HITCHCOCK		14. MOTHER'S MAIDEN NAME MARY E. BIAKENEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO -----	
17. INFORMANT Springfield State Hospital Records - Sykesville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO Conditions, if any, which gave rise to immediate cause (b) Unknown, but probably in convulsion (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour ----- a. m. ----- p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		DATE SIGNED 7/1/57	
EXAMINER'S NAME (Type) JAMES T. MARSH, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/4/57	22c. NAME OF CEMETERY OR CREMATOR FOREX M.B. OCM.	22d. LOCATION (City, town, or county) (State) FOREX MD.
23. FUNERAL DIRECTOR'S SIGNATURE Paul A. Heemann		24a. REC'D BY REGISTRAR 8/13/57	
ADDRESS 6067 Harford Rd.		24b. REGISTRAR'S SIGNATURE C. Harry Hepp	

MEDICAL CERTIFICATION

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07333 *Item 9 F.D. 210 7-29-57 et*
CERTIFICATE OF DEATH

Reg. Dist. No.

07318
74

1. PLACE OF DEATH o COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o STATE Maryland b. COUNTY Baltimore City 311			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY in 1b 10 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				d STREET ADDRESS 5354 Federal st. Baltimore 5			
3. NAME OF DECEASED (Type or print) First Ella Middle Virginia Last Jones.				4. DATE OF DEATH Month July Day 21 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 1987	
9. AGE (In years last birthday) 79 69 yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Cousins				14. MOTHER'S MAIDEN NAME Mary De waney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records.		Address Sykesville, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease 4443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH years years</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, ass. with disturbances of metabolism, growth or nutrition with senile brain disease with psychotic reactions.</p>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 304 X					
20c. TIME OF INJURY Month, Day, Year Hour o m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-17 , 19 56 , to 7-21- , 19 57 , that I last saw the deceased alive on 7-21- , 19 57 , and that death occurred at 1.10p.m. from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div> <p>ACTUAL SIGNATURE Agustin del Campo M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7-21-57</p> <p>PHYSICIAN'S NAME (Type) Agustin del Campo M.D. Sykesville, Maryland</p> </div> </div>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		JULY 24/57		WESTERN		BALTIMORE, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc. Baltimore, Md				24a. REC'D BY REGISTRAR DATE 7/21/57		24b. REGISTRAR'S SIGNATURE C. Harry Mary	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

1 1 M 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

7334

CERTIFICATE OF DEATH

07319
Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15x	
c. LENGTH OF STAY IN 1b 118 days		d. STREET ADDRESS Rt. 2, Box 95 Stewart Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Jones Jr. Last Jones Jr.		4. DATE OF DEATH Month July Day 27 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1927
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR: Months 29 Days 29 Hours 29 Min. 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Jones		14. MOTHER'S MAIDEN NAME Pearl ???	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 579-28-4779	
17. INFORMANT Frank Jones - Patient		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis with cavitation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cavitation DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 29, 1957 to July 26, 1957 , that I last saw the deceased alive on July 26, 1957 , and that death occurred at 1:30 AM , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) Henryton, Maryland	DATE SIGNED 7-27-57

ACTUAL SIGNATURE Dr. Edgar M. Maculans	M.D. Henryton, Maryland	DATE 7-27-57
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PHYSICIAN'S NAME (Type) Dr. Edgar M. Maculans	Henryton State Hospital, Henryton, Md
------------------------------------------------------	----------------------------------------------

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-1-57	22c. NAME OF CEMETERY OR CREMATORY Int Calvary	22d. LOCATION (City, town, or county) (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE M. Nelson		24a. REC'D BY REGISTRAR 1348 N. Calhoun St	
24b. REGISTRAR'S SIGNATURE Robert R. Southman		DATE 7-27-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

JUL 31 1957

RECEIVED

(7335)

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN TB 1 mo. 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick ✓			
d. STREET ADDRESS 11 East B Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elma Middle Carnetta Last LaPOLE				4. DATE OF DEATH Month July Day 31 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1918	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse's Aide				10b. KIND OF BUSINESS OR INDUSTRY 2 -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles LaPole				14. MOTHER'S MAIDEN NAME Lula Taulton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 214-20-7030		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrosis of brain, left hemisphere 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with unknown or unspecified cause, with psychotic reaction. 350X							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 21, 1957 , to July 31, 1957 , that I last saw the deceased alive on July 31, 1957 , and that death occurred at 9:00 AM , from the causes and on the date stated above							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				Springfield State Hospital 7/31/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
8-3-57		Reformed		Brunswick		MD	
23. FUNERAL DIRECTOR'S SIGNATURE E.H. Fick				24. REC'D BY REGISTRAR 1957			
24b. REGISTRAR'S SIGNATURE C. Harry							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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07336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGFIELD STATE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 1234	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>6406 CLEARSPRING Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Fredrick</u> Last <u>LEWIN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-92</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. UNDER 1 YEAR Months <u>64</u> Days <u>13</u> Hours <u>19</u> Min.	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Warrenton, Or.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Lewin</u>		14. MOTHER'S MAIDEN NAME <u>Anna Earthman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>1917-1919</u>		16. SOCIAL SECURITY NO. <u>218-148630</u>	
17. INFORMANT <u>Thelma Lewin (wife)</u>		Address <u>6406 CLEARSPRING</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CBS cerebral arteriosclerosis</u> (c) <u>Fever of unknown etiology</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6</u> <u>31</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>13</u> Year <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 18, 1957</u> to <u>July 13, 1957</u> , that I last saw the deceased alive on <u>July 13, 1957</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter H. Springfield</u> M.D.		ADDRESS (Street, city or town, state) <u>711-13-57</u>	
DATE SIGNED <u>7-13-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Seitz</u>		ADDRESS <u>5209 York Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>7/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry</u>	

U.S. AIR FORCE

16 1957

RECEIVED

07337

CERTIFICATE OF DEATH

Reg. Dist. No.

07322

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write CITY and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2-10-1942			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2811 Winchester St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John A. Mudd				4. DATE OF DEATH July 28 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 24 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. watchman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) White Plains Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Bernard Mudd			14. MOTHER'S MAIDEN NAME Annie Franklin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Address Springfield State Hospital- Sykesville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 minutes about 20 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with syphilitic meningo encephalitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield State Hospital		(County)	(State)
21. I certify that I attended the deceased from Jan. 17 1955 19 to & 7-28-57 19, that I last saw the deceased alive on July 28 1957 19 57 , and that death occurred at 9:00 a.m. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED Edmund Lusthaus M.D. Springfield State Hospital ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) EDMUND LUSTHAUS Sykesville Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/30/57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Schenck				24a. REC'D BY REGISTRAR DATE 7/29/57		24b. REGISTRAR'S SIGNATURE C. Harry Messer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 20 1957

BUREAU V. S.

07338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 2 yrs. 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2126 St. Paul Street	
3. NAME OF DECEASED (Type or print) First Anna Middle Christine Last OLSEN		4. DATE OF DEATH Month July Day 29 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Even Olsen		14. MOTHER'S MAIDEN NAME Inger Olsen Hansen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) 491X Branchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 301X (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with circulatory disturbance with cerebral arterio-sclerosis with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH 5 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1955 , to July 29, 1957 , that I last saw the deceased alive on July 29, 1957 , and that death occurred at 8:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/30/57			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/2/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Tom J. Lickner & Sons, Balto.		24a. REC'D BY REGISTRAR 7/31/57	24b. REGISTRAR'S SIGNATURE C. Harry Myers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 1 1957

BUREAU V. S.

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CERTIFICATE OF DEATH

07324-74

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 17 yrs.3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 406 Camden Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leonard Middle PEKTUS Last PEKTUS				4. DATE OF DEATH Month July Day 28 , Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1869	
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88		11. IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min. 88		12. IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min. 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Lithuania				12. CITIZEN OF WHAT COUNTRY? Lithuania ✓			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DOX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 306X (b) DOX DUE TO (c) DOX							INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1 , 19 50 , to July 28 , 19 57 , that I last saw the deceased alive on July 28 , 19 57 , and that death occurred at 11:40 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 7/29/57			
ACTUAL SIGNATURE Walther H. Sonnenfeldt				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Hanel		23a. REC'D BY REGISTRAR AUG 1 1957		23b. REGISTRAR'S SIGNATURE C. Harry Hery			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 mos. 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Wesley Last PRICE, Sr.		4. DATE OF DEATH Month July Day 22 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1883
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 73 Days 73 Hours 73 Min 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Price		14. MOTHER'S MAIDEN NAME Mannie Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO -	
17. INFORMANT Springfield State Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH Years Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 19, 1957 , to July 22, 1957 , that I last saw the deceased alive on July 22, 1957 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 7/22/57	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) g	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Ave.		ADDRESS 24a REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE JUL 24 1957 C. Harry Heery	

RECEIVED

JUL 24 1957

BUREAU Y. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07327

Reg. Dist. No. 81

07341

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2011</u>		d. STREET ADDRESS <u>30 W. BROADWAY</u>	
3. NAME OF DECEASED (Type or print) <u>WILSON HANSBROUGH QUESENBERRY</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 31, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>CROCKETT QUESENBERRY</u>		14. MOTHER'S MAIDEN NAME <u>NANCY DUNCAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Russell V. Lushby</u>		Address <u>Linnwood, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler & Sons, Union Bridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/9/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Leslie L. Rapp</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1957

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CERTIFICATE OF DEATH

07328

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 7 mos. 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS 5507 Craig Avenue	
3. NAME OF DECEASED (Type or print) First Maud Middle Mary Last REES		4. DATE OF DEATH Month July Day 10 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1875
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Rees		14. MOTHER'S MAIDEN NAME Elsa Holt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO unk.	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of aorta due to arteriosclerosis 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, without qualifying phrase.			INTERVAL BETWEEN ONSET AND DEATH Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from November 11, 1956 , to July 10, 1957 , that I last saw the deceased alive on July 9, 1957 , and that death occurred at 3:20 A.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Walther H. Sonnenfeldt, M.D. Springfield State Hospital		DATE SIGNED 7/10/57	
ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D.		PHYSICIAN'S NAME (Type) Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-13-57	
22c. NAME OF CEMETERY OR CREMATORY Shut Lincoln		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Luther H. Knight		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR DATE 7-11-57		24b. REGISTRAR'S SIGNATURE C. Harry Weed	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician. Page 2 may be signed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUL 12 1957

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CERTIFICATE OF DEATH

07329

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster, R-3, Myers District</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>—</u> Last <u>Sell</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework, Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home.</u>	11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Lippy</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Serenus Sell</u> Address <u>Serenus Sell, R. D. 3, Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diaheria</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>6 Mon</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>420.0</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>July 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>57</u> , and that death occurred at <u>2</u> <u>PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Ford</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md.</u> DATE SIGNED <u>7/22/57</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Ford, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bixlers U.B. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Nr. Westminster, Carroll Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>		ADDRESS <u>Littlestown, Pa.</u>	24a. REC'D BY REGISTRAR DATE <u>7-24-57</u>
		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 26 1957

RECEIVED

[illegible]

07308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>9 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 JOHN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NELLIE CATHERINE SENTZ</u>		4. DATE OF DEATH <u>JULY 22 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 3-1965</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE + CLERK LUNCH ROOM MD</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES L. FOX</u>		14. MOTHER'S MAIDEN NAME <u>ELVIA HINDIG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>22-16-079</u>	
17. INFORMANT <u>MRS. GEO. HARRIS WESTMINSTER, MD</u>		Address <u>RD 4</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>15 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442A</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/6</u> 19 <u>57</u> to <u>7/22</u> 19 <u>57</u> that I last saw the deceased alive on <u>7/22</u> 19 <u>57</u> and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Allen Moulton</u> M.D.		DATE SIGNED <u>7/27/57</u>	
PHYSICIAN'S NAME (Type) <u>G. ALLEN MOULTON, M.D.</u>		ADDRESS (Street, city or town, state) <u>Westminster Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bannard Westminster</u>		24a. REC'D BY REGISTRAR <u>Harriet Moulton</u>	
ADDRESS <u>Westminster</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>7-26-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

BUREAU V. 3

JUL 29 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07331

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield Share Hospital</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland, Md.</u> d. STREET ADDRESS <u>Route 1, Oakland</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Daniel Sr. Shaeffer</u>			4. DATE OF DEATH Month Day Year <u>7 19 19 57</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-24-81</u>		9. AGE (In years and birthday) <u>75 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours M n <u>7 19 19 57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawmill operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Yuk</u>		
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Henry Shaeffer</u>			14. MOTHER'S MAIDEN NAME <u>Anna</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unkn</u>		16. SOCIAL SECURITY NO. <u>Unkn</u>		17. INFORMANT <u>S.S. Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> <u>441X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic heart disease</u> <u>2X500</u> (c) <u>Fractured 7,8,9 left ribs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. brain syndr. with cerebral arteriosclerosis with psychosis</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>unknown; apparently prior to admission to this hospital</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unkn</u>	
20f. (City or town) <u>Unkn</u>		20g. (County) <u>Unkn</u>		20h. (State) <u>Unkn</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James T. Marsh</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>James T. Marsh</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>7-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Anora</u>
22d. LOCATION (City, town, or county) <u>Anora, W. Va.</u>			22e. (State) <u>W. Va.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas Roy Golden - Oakland, Md.</u>			24a. REC'D BY REGISTRAR <u>C. Harry Allen</u>		
24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>			DATE <u>7-20-57</u>		

RECEIVED

JUL 24 1957

BUREAU OF

07309

CERTIFICATE OF DEATH

07332

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 170 E. Green St.		d. STREET ADDRESS 170 E. Green St.	
3. NAME OF DECEASED (Type or print) First George Middle Morgan Last Simpson		4. DATE OF DEATH Month July Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.	IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Paper Dist.	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Francis Marion Simpson	
14. MOTHER'S MAIDEN NAME Mary McTaggart		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 450.0		17. INFORMANT Mrs. Anna Boyd Simpson Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Chronic Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 years (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/4 , 19 57 , to 7/4 , 19 57 , that I last saw the deceased alive on 7/4 , 19 57 , and that death occurred at 6:17 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Luther Bare		DATE SIGNED Westminster, Maryland 7/5/57	
PHYSICIAN'S NAME (Type) S. Luther Bare, M. D.		79 W. Main St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-7-57	22c. NAME OF CEMETERY OR CREMATORY Krider's Cemetery	22d. LOCATION (City, town, or county) (State) nr Westminster, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Maryland		24a. REC'D BY REGISTRAR DATE 7-8-57	24b. REGISTRAR'S SIGNATURE Harriet Miller

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached to the certificate by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 1 1907

RECEIVED

C7345

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 12 yrs. 8 mos. 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Skrypek Last Skrypek				4. DATE OF DEATH Month July Day 9 Year 19 57			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1893		9. AGE (In years last birthday) 63 yrs	IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY - Unk.		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? Austria ✓	
13. FATHER'S NAME John Skrypek				14. MOTHER'S MAIDEN NAME Rosa Bubula			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Springfield Hospital records. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 321X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia reaction, paranoid type. 300.3							INTERVAL BETWEEN ONSET AND DEATH 2 days Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1, 19 50 , to July 9, 19 57 , that I last saw the deceased alive on July 9, 19 57 , and that death occurred at 11: A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				DATE SIGNED 7/9/57			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-11-57		Springfield		Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight				24a. REC'D BY REGISTRAR DATE 7-10-57		24b. REGISTRAR'S SIGNATURE R. Henry Allen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

12 1957

RECEIVED

07346

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 mo. 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Reid Last SMITH				4. DATE OF DEATH Month July Day 31 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 29, 1876	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown			
13. FATHER'S NAME Mose Smith				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) National Guard		16. SOCIAL SECURITY NO. 220-09-4887		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Hours Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 1957 , to July 31, 1957 , that I last saw the deceased alive on July 30, 1957 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 7/31/57	
PHYSICIAN'S NAME (Type) Agustin del Campo				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-3-57		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Plonowski, Jr.				ADDRESS 3615 Chestnut Ave. Balt.		24b. REC'D BY REGISTRAR C. Harry Zuer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7347

CERTIFICATE OF DEATH

Reg. Dist. No. 07335

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 4600 Valley View Ave.					
3. NAME OF DECEASED (Type or print) William Middle Boston Last SMITH		4. DATE OF DEATH Month July Day 24, Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH September 20, 1883		9. AGE (In years last birthday) 73 7/8 yrs <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">IF UNDER 1 YEAR</td> <td style="width: 25%;">IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days
IF UNDER 1 YEAR	IF UNDER 24 HRS						
Months	Days						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker		10b. KIND OF BUSINESS OR INDUSTRY YMC					
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Boston Smith		14. MOTHER'S MAIDEN NAME Catherine Roben					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 216-05-1749A					
17. INFORMANT Springfield Hospital Records.		Address					

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Bronchopneumonia Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Years Days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with circ. dist. with cerebral arteriosclerosis with psychotic reaction. Cancer of the tongue.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 28, 1957, to July 24, 1957, that I last saw the deceased alive on July 24, 1957, and that death occurred at 7:35P M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/25/57

ACTUAL SIGNATURE Agustin del Campo M.D. Sykesville, Md.

PHYSICIAN'S NAME (Type) Agustin del Campo

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-24-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John H. H. 4210 Belair Rd. Balt.		24a. REC'D BY REGISTRAR DATE 7-25-57	24b. REGISTRAR'S SIGNATURE O. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAU V. S.

17 26 1957

RECEIVED

(7348)

CERTIFICATE OF DEATH

Reg. Dist. No.

94

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 mos. 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3207 Independence St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Annie Corrilla Hinton TAYLOR		4. DATE OF DEATH Month Day Year July 23, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1870
9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Hinton		14. MOTHER'S MAIDEN NAME Margaret Maddon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, right lung 420.1 DOXO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Old myocardial infarction of left ventricle wall Years DUE TO (c) Coronary arteriosclerosis Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 1957 to 7-23- 1957 , that I last saw the deceased alive on 7-23- 1957 , and that death occurred at 6.40 p. M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 7-23-57	
ACTUAL SIGNATURE Walter H. Sonnenfeldt M.D.			
PHYSICIAN'S NAME (Type) Walter H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27 1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Melville Jenkins		ADDRESS 2713 Kirk Ave	
24a. REC'D BY REGISTRAR 7/26/57		24b. REGISTRAR'S SIGNATURE C. Harry Sears	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 195

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll County, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Sykesville, Maryland				c. LENGTH OF STAY IN lb 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Benson Taylor				4. DATE OF DEATH 7 21 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-1870	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Alfred Taylor				14. MOTHER'S MAIDEN NAME Virginia Boggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Minutes Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to cerebral arteriosclerosis with psychosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-11-1957 to 7-21 19 57 , that I last saw the deceased alive on 7-21 19 57 , and that death occurred at 11:55 A. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrude M. Gross, M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 7-21-1957							
PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Smithland Md	
23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME				ADDRESS 4812-GA, AVE Wash. DC		24a. REC'D BY REGISTRAR 11 24	
24b. REGISTRAR'S SIGNATURE C. H. Myers							

BUREAU V. S.

JUL 29 1957

RECEIVED

Item 3: G218 7-24-57 L

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 32 y1 m 28 d			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 309 S. Eden Street			
3. NAME OF DECEASED (Type or print) First Dominic Middle DELLA Last VIOLA				4. DATE OF DEATH Month 7 Day 28 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879 P	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? unknown							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Grace Divilmo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. unkn		17. INFORMANT S.S. Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia due to undetermined cause DUE TO 491 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic psychosis 308.1				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-20-1954 to 7-19-57 , that I last saw the deceased alive on 7-19-1957 , and that death occurred at 4:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Luthaus M.D. Springfield State Hospital 7-20-57							
ACTUAL SIGNATURE Edmund Luthaus M.D. Springfield State Hospital 7-20-57							
PHYSICIAN'S NAME (Type) Edmund Luthaus Sykesville, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 24 1957		Most Holy Redeemer		Balwin Road Md	
23. FUNERAL DIRECTOR'S SIGNATURE Richard J. Kippel				24a. REC'D BY REGISTRAR July 20 1957			
ADDRESS				24b. REGISTRAR'S SIGNATURE C. Harry Hess			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

76

07310

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER Rural X2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COUNTY HOME</u>				d. STREET ADDRESS <u>CLAYTON HAVEN</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACOB RINEHART ZILE</u>				4. DATE OF DEATH Month Day Year <u>JULY 9 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 21-1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FATHERS FARM</u>		11. BIRTHPLACE (State of foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEONARD ZILE</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET STEVENSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GERTRUDE LAMBERT NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio vas. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>no cause</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>no 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>no</u>		20f. (City or town) (County) (State) <u>no</u>	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> to <u>7-9</u> , 19 <u>57</u> that I last saw the deceased alive on <u>July 8</u> , 19 <u>57</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>W. C. Stone</u> M.D. <u>Westminster</u> PHYSICIAN'S NAME (Type) <u>W. C. Stone</u> <u>WESTMINSTER MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DR Hartzler & Sons, New Windsor Md</u>				24a. REC'D BY REGISTRAR DATE <u>7/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Mullis</u>	

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BUREAU V. 5

JUL 12 1957

RECEIVED